

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

TN4703

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: 01 - MAIN BUILDING 01

B. WING

(X3) DATE SURVEY
COMPLETED

03/06/2017

NAME OF PROVIDER OR SUPPLIER

SUMMIT VIEW OF FARRAGUT, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

12823 KINGSTON PIKE

KNOXVILLE, TN 37923

(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETE
DATE

N 002 1200-8-6 No Deficiencies

N 002

During the Life Safety portion of the annual
licensure survey conducted on 3/6/17, no
deficiencies were cited under 1200-08-06,
Standards for Nursing Homes.

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

FXLB21

3-28-17

If continuation sheet 1 of 1